

751 CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <i>Kent</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md.</i> b. COUNTY <i>Kent</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Millington</i>				c. LENGTH OF STAY IN 1b <i>1 x 2 1/2</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <i>1</i>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <i>JOHN M ATKINSON</i>				4. DATE OF DEATH Month Day Year <i>Jan. 3 1957</i>			
5. SEX <i>male</i>	6. COLOR OF RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 2, 1889</i>		9. AGE (In years last birthday) <i>67</i> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Linted Farm</i>		11. BIRTHPLACE (State or foreign country) <i>md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Jessie Atkinson</i>				14. MOTHER'S MAIDEN NAME <i>Hannah M. E. Taylor</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <i>214-34-6107</i>		17. INFORMANT <i>Kenneth Atkinson Millington Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Myocardial Insufficiency</i> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>sudden</i> <i>3 mos</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>bronchectasis</i>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no injury</i>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) <i>Millington Md</i>		(County) (State)	
21. I certify that I attended the deceased from <i>12/12/56</i> , 19____, to <i>1/3/57</i> , 19____, that I last saw the deceased alive on <i>12/14/56</i> , 19____, and that death occurred at <i>10:30 A.M.</i> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. H. Hamilton</i>				DATE SIGNED <i>1/5/57</i>			
PHYSICIAN'S NAME (Type) <i>J. H. Hamilton</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Jan. 6, 1957</i>		<i>Wesley Chapellem.</i>		<i>Rock Hall Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Vellor Millington Md</i>				24a. REC'D BY REGISTRAR <i>JAN 9 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Ely. Mulford</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

JAN 9 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

007422

746

1. PLACE OF DEATH a. COUNTY Kent MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Kent		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN 1b Life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown 37		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 533 High st.			d. STREET ADDRESS 533 High st.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Daisy First Middle O. Last Barnes			4. DATE OF DEATH January Month Day 7 Year 19 57		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/19/1887		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secty.		10b. KIND OF BUSINESS OR INDUSTRY Bookkeeping		11. BIRTHPLACE (State or foreign country) Chestertown	
12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME John W. Barnes			14. MOTHER'S MAIDEN NAME Sahah Crouch		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 212-03-8134		17. INFORMANT Earle Barnes, Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH Short
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Robert W. Farr, M. D.			DATE SIGNED Jan. 8, 1957		
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/9/57		22c. NAME OF CEMETERY OR CREMATORY Chester Cemetery	
22d. LOCATION (City, town, or county) Chestertown, Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Jan. 10-57	
24b. REGISTRAR'S SIGNATURE Class S. Barnes					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ILLINOIS STATE DEPARTMENT OF HEALTH - CHICAGO, ILL.
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
FATHER'S NAME		MOTHER'S NAME		MARRIED		SINGLE		WIDOWED		DIVORCED		RECEIVED		RECEIVED		RECEIVED	
OCCUPATION		EDUCATION		RELIGION		POLITICAL PARTY		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE		MILITARY SERVICE	
PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS	
CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH		CAUSE OF DEATH	
MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH		MANNER OF DEATH	
TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH		TIME OF DEATH	
PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH		PLACE OF DEATH	
SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER		SIGNATURE OF EXAMINER	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	

BUREAU V. E.

JAN 14 1957

RECEIVED

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
747
CERTIFICATE OF DEATH

00743

Reg. Dist. No. 202

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN				c. LENGTH OF STAY IN 1b 16 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION KENT & QUEEN ANNE'S				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MABEL LOUISE ROWSER				4. DATE OF DEATH Month JAN Day 11 Year 1957			
5. SEX F	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 11, 1895		9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR: Months 11 Days 11 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWORK				10b. KIND OF BUSINESS OR INDUSTRY Md.		11. BIRTHPLACE (State or foreign country) USA.	
13. FATHER'S NAME GEORGE DAVIS				14. MOTHER'S MAIDEN NAME CARRIE LEE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. -		17. INFORMANT HOSPITAL CHART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 561.2 INTESTINAL OBSTRUCTION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) STRANGULATED UMBILICAL HERNIA DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 4 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 1. Month 19 Day 19 Year 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from JAN 10, 1957 to JAN 11, 1957 , that I last saw the deceased alive on JAN 11, 1957 , and that death occurred at 4⁴⁵ M, from the causes and on the date stated above.							
ACTUAL SIGNATURE A. T. Keefe, Jr.				ADDRESS (Street, city or town, state) CHESTERTOWN, Md			
PHYSICIAN'S NAME (Type) A. T. KEEFE, JR. M.D.				DATE SIGNED 1-11-57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 14, 1957		22c. NAME OF CEMETERY OR CREMATORY Davis Hill Cem.		22d. LOCATION (City, town, or county) (State) near Galena - Kent Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells				ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR Jan. 14-57	
				24b. REGISTRAR'S SIGNATURE Clara S. Barnes			

752

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Worton				c. LENGTH OF STAY IN 1b 40 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION -----				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Ellen Last Boyer				4. DATE OF DEATH Month January Day 29 Year 19 57			
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1886	9. AGE (In years last birthday) yrs. 70	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Samuel L. Johnson				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Gertrude Johnson, Worton, R.F.D. Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Sensibility						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from January, 1956 , to January, 1957 , that I last saw the deceased alive on January 21, 1957 , and that death occurred at 3:45 P.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED Jan 29/57	
ACTUAL SIGNATURE E. Kester		M.D.		PHYSICIAN'S NAME (Type) Eugene Kester		Rock Hall, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-1-57		22c. NAME OF CEMETERY OR CREMATORY Fountain Cemetery		22d. LOCATION (City, town, or county) (State) Worton, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy		ADDRESS Still Pond, Md.		24a. REC'D BY REGISTRAR DATE 1/31/57		24b. REGISTRAR'S SIGNATURE E. Kennedy Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. H.

FEB 4 1957

RECEIVED

15. 12. 1950

753 CERTIFICATE OF DEATH

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Worton		c. LENGTH OF STAY IN 1b Lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ---		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XO Rural Worton	
		d. STREET ADDRESS /	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Brooks Last Brooks		4. DATE OF DEATH Month January Day 20 Year 1957	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 24. 1955
9. AGE (In years lost birthday) yrs. 1		IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Bernard Brooks		14. MOTHER'S MAIDEN NAME Helen Dorsey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Aldridge Dorsey		Address Worton, R. D. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) acute pulmonary edema DUE TO (b) Congenital heart disease DUE TO (c) generalized poor protoplasm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 15 min. lifetime	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) poor assimilation of food		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from birth , 19 Jan 20 , 19 57 , that I last saw the deceased alive on Jan 18 , 19 57 , and that death occurred at 10:00 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Florence D. Joyce M.D.		ADDRESS (Street, city or town, state) Worton, Md. DATE SIGNED 1-21-57	
PHYSICIAN'S NAME (Type) Florence D. Joyce		Worton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 1-20-57	22c. NAME OF CEMETERY OR CREMATORY Coleman Cemetery	22d. LOCATION (City, town, or county) (State) Worton, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy		ADDRESS Still Pond, Md.	
24a. REC'D BY REGISTRAR 1/21/56		24b. REGISTRAR'S SIGNATURE C. Kennedy Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

DECEASED

DATE

AGE

PLACE OF BIRTH

DATE OF BIRTH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

From examination of food
 General heart disease
 acute pulmonary infection

BUREAU V. S.

Jan 20 1957

Jan 22 1957

Received Jan 18 1957

RECEIVED
 JAN 23 1957

Victor J. Kennedy

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

748

CERTIFICATE OF DEATH

00746

Reg. Dist. No. 201

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chesler Town</u>				c. LENGTH OF STAY IN 1b <u>Shrs-11 min</u> <u>10</u> <u>Worton</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Kent & Queen Anne's Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carter</u>				4. DATE OF DEATH Month Day Year <u>January 20 1957</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JANUARY 29 1957</u>		9. AGE (In years lost birthday) yrs. <u>5</u> <u>11</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Donald Harper Carter</u>				14. MOTHER'S MAIDEN NAME <u>Alta Elizabeth Stowman</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u>		Address <u>Worton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-20</u> , 19 <u>57</u> , to <u>1-20</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>1-20</u> , 19 <u>57</u> , and that death occurred at <u>5:15</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md</u> DATE SIGNED <u>1-20-57</u>							
ACTUAL SIGNATURE <u>A.C. Dick</u>				M.D. <u>Chestertown, Md</u>			
PHYSICIAN'S NAME (Type) <u>A.C. Dick</u>				<u>Chestertown Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1-21-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMTY</u>		22d. LOCATION (City, town, or county) (State) <u>STILL POND MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Victor N. Kennedy</u> ADDRESS <u>STILL POND, MD.</u>				24a. REC'D BY REGISTRAR DATE <u>1/21/56</u>		24b. REGISTRAR'S SIGNATURE <u>E. Kennedy Jones</u>	

2072202XVI

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, cause of death, and location. The form is mostly blank with some faint, illegible markings.

BUREAU V. S.

JAN 23 1957

RECEIVED

BURIAL 1-21-57 STILL BOND CEMTARY STILL BOND MD

754

CERTIFICATE OF DEATH

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Kent</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millington</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ROBBINS NURSING HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>CLARK</u> Last <u>CLARK</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>7</u> Year <u>1957</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 12, 1872</u>		9. AGE (In years last birthday) <u>84</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHOE</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHANIEL H. CLARK</u>				14. MOTHER'S MAIDEN NAME <u>MARY SEENEY</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>W.C. HOLDEN</u>		Address <u>Box 6, DOVER, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) <u>Senility</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>year</u> <u>5 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>196X Cancer L jaw</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
				20f. (City or town) <u> </u>		(County) (State)	
21. I certify that I attended the deceased from <u>3/25/50</u> , 19 <u> </u> , to <u>1/7/57</u> , 19 <u> </u> , that I last saw the deceased alive on <u>Jan 6</u> , 19 <u>57</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Millington Md</u> DATE SIGNED <u>1/9/59</u>							
ACTUAL SIGNATURE <u>H. H. Hamilton</u>				M.D. <u>Millington Md</u>			
PHYSICIAN'S NAME (Type) <u>H. H. HAMILTON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>1/10/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CRUMPTON CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CRUMPTON, D.C. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>				ADDRESS <u>Millington, Del.</u>		24a. REC'D BY REGISTRAR <u>JAN 11 1959</u>	
				24b. REGISTRAR'S SIGNATURE <u>Chas. Mulford</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 14 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

755

CERTIFICATE OF DEATH

Reg. Dist. No.

00748

203

1. PLACE OF DEATH a. COUNTY <u>KENT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>KENT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCK HALL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 ROCK HALL</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAGGIE</u> Middle <u>G.</u> Last <u>COLEMAN</u>		4. DATE OF DEATH Month <u>JAN.</u> Day <u>19</u> Year <u>1957</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 13 - 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN GRULSKY</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MRS. MILTON GLENN -</u>		Address <u>ROCK HALL</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral arteriosclerosis</u> <u>334X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan. 18, 1957</u> to <u>Jan. 19, 1957</u> , that I last saw the deceased alive on <u>Jan. 18, 1957</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Rock Hall, Md. 1/24/57</u>			
ACTUAL SIGNATURE <u>Willard J. Smith</u> M.D.		PHYSICIAN'S NAME (Type) <u>Rock Hall, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>JAN. 22</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>WESLEY CHAPEL</u>		22d. LOCATION (City, town, or county) (State) <u>ROCK HALL MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar D. Lane - Church Hill, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE 1/22/57</u>	
24b. REGISTRAR'S SIGNATURE <u>Edwood Eugene</u>			

BUREAU V. S.

JAN 24 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

756

CERTIFICATE OF DEATH

00749

Reg. Dist. No. 203

1. PLACE OF DEATH o. COUNTY <u>Rock Hall</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>dent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	c. LENGTH OF STAY IN 1b <u>15 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Elva</u> Middle <u>Mary</u> Last <u>Conner</u>		4. DATE OF DEATH Month <u>January</u> Day <u>14</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 15 - 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>14</u> Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>John Dixon</u>	
14. MOTHER'S MAIDEN NAME <u>Unborn</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>1</u>		17. INFORMANT <u>Mrs Vernon Baker</u> Address <u>Rock Hall</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Congestive heart failure & pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic heart disease & thrombosis</u> DUE TO (c) <u>3 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Oct. 1, 1956</u> to <u>Jan. 14, 1957</u> , that I last saw the deceased alive on <u>Jan. 12, 1957</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Willard F. Smith</u> M.D.		ADDRESS (Street, city or town, state) <u>Rock Hall, Md.</u>	
PHYSICIAN'S NAME (Type) <u>WILLARD F. SMITH, MD</u>		DATE SIGNED <u>1/15/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>1-16-57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel</u>	22d. LOCATION (City, town, or county) (State) <u>Rock Hall Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar L. Lane</u>		ADDRESS <u>Church Hill</u>	24a. REC'D BY REGISTRAR DATE <u>1/16/57</u>
		24b. REGISTRAR'S SIGNATURE <u>D. Shwood Banger</u>	

BUREAU V. S.

JAN 21 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00750

Reg. Dist. No.

200

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - galena		c. LENGTH OF STAY IN 1b Rock Hall x2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) FRANCES BENTON DU VALL		4. DATE OF DEATH January 9 1957	
5. SEX 7	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-27-1922
9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Benton		14. MOTHER'S MAIDEN NAME Helen Du Vall	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 1		16. SOCIAL SECURITY NO. 215-149153	
17. INFORMANT R. Benson Du Vall - Rock Hall Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple severe crushing injury DUE TO to chest Conditions, if any, which gave rise to immediate cause (b) None (a), stating the underlying cause lost. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Deceased drove car on to chimney and collected with on company car was apparently thrown from car + run over by other vehicle	
20c. TIME OF INJURY Month, Day, Year 1/9 1957		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY Home, farm, factory, street, office bldg., etc.) Galena		20f. (City or town) (County) (State) Kent Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) ROBERT W. FARR		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 1-12	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane - Church Hill Rd.		24a. REC'D BY REGISTRAR 1/9/57	
ADDRESS		24b. REGISTRAR'S SIGNATURE Edg. Mulford	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with file registrar prior to burial, cremation or removal.

RECEIVED

JAN 14 1957

BUREAU Y. S.

STATE OF NEW YORK
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: _____
2. SEX: _____
3. AGE: _____
4. DATE OF BIRTH: _____
5. PLACE OF BIRTH: _____
6. OCCUPATION: _____
7. CAUSE OF DEATH: _____
8. MANNER OF DEATH: _____
9. SIGNATURE OF MEDICAL EXAMINER: _____
10. DATE OF EXAMINATION: _____

11. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

12. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

13. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

14. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

15. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

16. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

17. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

18. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

19. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

20. I hereby certify that the above is a true and correct statement of the facts ascertained by me in my examination of the body of the deceased.

758
CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH o. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY KENT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) CHARLES First FREDERICK Middle JACOB Last		4. DATE OF DEATH Month JAN. Day 8 Year 1957	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAR. 16 - 1894
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAW-BRIDGE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HERMAN JACOB		14. MOTHER'S MAIDEN NAME MINNIE KIRSNECK	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) #1 War.		16. SOCIAL SECURITY NO. 220-32-9786	
17. INFORMANT MRS. CHAS. JACOB - ROCK HALL MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Cordis Vascular DUE TO (c) Coronary Insufficiency			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) arterio sclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 8, 1955 to Jan 8, 1957 , that I last saw the deceased alive on Jan 7, 1957 , and that death occurred at 5:30 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert C. Nitsch M.D.		DATE SIGNED Jan 8/57	
PHYSICIAN'S NAME (Type) NORBERT C. NITSCH - ROCK-HALL - MD			
22a. BURIAL, CREMATION, REMOVAL (Specify) JAN. 10	22b. DATE THEREOF JAN. 10	22c. NAME OF CEMETERY OR CREMATORY ST. PAUL	22d. LOCATION (City, town, or county) (State) RURAL ROCK HALL MD.
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Kane		24a. REC'D BY REGISTRAR DATE 1/10/57	24b. REGISTRAR'S SIGNATURE S. Shrood

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JAN 15 1957

RECEIVED

749

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

702

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown		c. LENGTH OF STAY IN lb 1 week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) XIMASSEY		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kent & Queen Annes				d. STREET ADDRESS 1 None			
3. NAME OF DECEASED (Type or print) Edward First Middle Last				4. DATE OF DEATH Month January Day 8 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 25, 1892		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Johnson				14. MOTHER'S MAIDEN NAME Matilda Bushrod			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unknown		16. SOCIAL SECURITY NO. 216-18-8879		17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cholecystitis, Gangrenousm acute 591X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Uremia DUE TO (c) Lower Nephron Nephrosis						INTERVAL BETWEEN ONSET AND DEATH 7 days 7-10 days 7-10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pericarditis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>Robert W. Farr</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) Robert W. Farr, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Jan 9, 1957	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan 12 1957		New Bethel Am.		Galt m.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edward Yellow</i>				ADDRESS <i>Millington Md.</i>		24a. REC'D BY REGISTRAR DATE JAN 14 1957	
				24b. REGISTRAR'S SIGNATURE <i>Clara Barnes</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death		Place of Death		Cause of Death		Manner of Death	
John Doe		Male		45		White		1957		Home		Heart Disease		Natural	
Occupation		Education		Marital Status		Previous Illnesses		Alcohol Consumption		Tobacco Use		Drugs		Other	
Teacher		High School		Married		Hypertension		Occasional		Daily		None		None	
Signature of Examiner		Signature of Coroner		Signature of Physician		Signature of Medical Examiner		Signature of Registrar		Signature of Funeral Home		Signature of Family		Signature of Other	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.

JAN 14 1957

RECEIVED

759

CERTIFICATE OF DEATH

Reg. Dist. No.

202

1. PLACE OF DEATH a. COUNTY KENT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ARNOLD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS JOYCE LANE	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle COLLISON Last JOYCE		4. DATE OF DEATH Month 1 Day 3 Year 1957	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/12/1877
9. AGE (In years last birthday) yrs. 79		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DENTIST		10b. KIND OF BUSINESS OR INDUSTRY PRIVATE PRACT	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CYRUS NEWTON JOYCE		14. MOTHER'S MAIDEN NAME MARY COLLISON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. JOHN RODGERS JOYCE JR	
17. INFORMANT JOHN RODGERS JOYCE JR		Address ARNOLD MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 5 min.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on never , 19____, and that death occurred at 6:40 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Florence Deringer Joyce M.D. WORTON, Md PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE MD			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	Jan 5-1957	London Park	Baltimore Md.
23. FUNERAL DIRECTOR'S SIGNATURE Baltimore Ave 2224		24a. REC'D BY REGISTRAR DATE 1/4/57	24b. REGISTRAR'S SIGNATURE Clara S. Barnes

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director should be filled in by the funeral director, and the certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

NAME		KENT	
RACE		WHITE	
AGE		77	
SEX		M	
DATE OF BIRTH		JAN 1 1877	
PLACE OF BIRTH		BALTIMORE, MARYLAND	
OCCUPATION		DENTIST	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
SIGNATURE OF PHYSICIAN		[Signature]	
SIGNATURE OF WITNESSES		[Signatures]	
DATE OF DEATH		JAN 1 1957	
PLACE OF DEATH		BALTIMORE, MARYLAND	

BUREAU V. 3

1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00754

760

CERTIFICATE OF DEATH

Reg. Dist. No.

201

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENNEDYVILLE Md				c. LENGTH OF STAY IN 1b 50		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KENNEDYVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES First MILLER JR Middle MILLER Last				4. DATE OF DEATH Month JANUARY Day 25 Year 1957			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 4, 1890	
9. AGE (In years last birthday) 66 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMING		10b. KIND OF BUSINESS OR INDUSTRY RET. FARM OWNER		11. BIRTHPLACE (State or foreign country) KENT Co., Md	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME CHARLES MILLER			
14. MOTHER'S MAIDEN NAME MARY E. MEIER				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. 220-34-9834				17. INFORMANT Charles E. MILLER Address KENNEDYVILLE			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT POSTERO LATERAL MYOCARDIAL INFARCT healed INTERVAL BETWEEN ONSET AND DEATH 5 min							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. 5 p. m. Month, Day, Year 1957				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) WORTON, Md				20g. (County) STILL POND, MD.		20h. (State) MD.	
21. I certify that I attended the deceased from October, 1954 , to Jan , 19 57 , that I last saw the deceased alive on Jan 21 , 19 57 , and that death occurred at 3:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) WORTON, Md DATE SIGNED 1-25-57							
ACTUAL SIGNATURE Florence Deringer Joyce M.D. WORTON, Md							
PHYSICIAN'S NAME (Type) FLORENCE DERINGER JOYCE							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF JAN. 27, 1957		22c. NAME OF CEMETERY OR CREMATORY CHESTER CEMT		22d. LOCATION (City, town, or county) (State) CHESTERTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Victor M. Kennedy				ADDRESS STILL POND, MD.		24a. REC'D BY REGISTRAR DATE 1/26/57	
24b. REGISTRAR'S SIGNATURE E. Kennedy Jones							

FLORENCE BERINGER, Joyce

EX-147 JAN 25 1957 CHESTER COUNTY YTMBO

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JAN 29 1952 - 25

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00755

761

CERTIFICATE OF DEATH

Reg. Dist. No. 203

1. PLACE OF DEATH a. COUNTY KENT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY KENT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCK HALL				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 ROCK HALL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last AUGUST FREDERICK MYERS				4. DATE OF DEATH Month Day Year JAN. 28 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1882 74 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PENSIONED FIRE-MAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Myers				14. MOTHER'S MAIDEN NAME Elizabeth Kettler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address EMIL MYERS = ROCK HALL MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral arteriosclerosis 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I attended the deceased from Jan. 1952 , 19____, to Jan. 28, 1957 , that I last saw the deceased alive on Jan. 21, 1957 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Willard J. Smith MD				ADDRESS (Street, city or town, state) Rock Hall, Md.			
PHYSICIAN'S NAME (Type) Willard J. Smith				DATE SIGNED 1/28/57			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 30		22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar A. Kane				ADDRESS Church Hill		24a. REC'D BY REGISTRAR DATE 1/28/57	
				24b. REGISTRAR'S SIGNATURE D. Howard Bungeas			

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. RACE		5. BIRTH DATE		6. BIRTH PLACE	
7. DECEASED DATE		8. DECEASED TIME		9. DECEASED PLACE	
10. DECEASED TIME		11. DECEASED PLACE		12. DECEASED PLACE	
13. DECEASED PLACE		14. DECEASED PLACE		15. DECEASED PLACE	
16. DECEASED PLACE		17. DECEASED PLACE		18. DECEASED PLACE	
19. DECEASED PLACE		20. DECEASED PLACE		21. DECEASED PLACE	
22. DECEASED PLACE		23. DECEASED PLACE		24. DECEASED PLACE	
25. DECEASED PLACE		26. DECEASED PLACE		27. DECEASED PLACE	
28. DECEASED PLACE		29. DECEASED PLACE		30. DECEASED PLACE	
31. DECEASED PLACE		32. DECEASED PLACE		33. DECEASED PLACE	
34. DECEASED PLACE		35. DECEASED PLACE		36. DECEASED PLACE	
37. DECEASED PLACE		38. DECEASED PLACE		39. DECEASED PLACE	
40. DECEASED PLACE		41. DECEASED PLACE		42. DECEASED PLACE	
43. DECEASED PLACE		44. DECEASED PLACE		45. DECEASED PLACE	
46. DECEASED PLACE		47. DECEASED PLACE		48. DECEASED PLACE	
49. DECEASED PLACE		50. DECEASED PLACE		51. DECEASED PLACE	
52. DECEASED PLACE		53. DECEASED PLACE		54. DECEASED PLACE	
55. DECEASED PLACE		56. DECEASED PLACE		57. DECEASED PLACE	
58. DECEASED PLACE		59. DECEASED PLACE		60. DECEASED PLACE	
61. DECEASED PLACE		62. DECEASED PLACE		63. DECEASED PLACE	
64. DECEASED PLACE		65. DECEASED PLACE		66. DECEASED PLACE	
67. DECEASED PLACE		68. DECEASED PLACE		69. DECEASED PLACE	
70. DECEASED PLACE		71. DECEASED PLACE		72. DECEASED PLACE	
73. DECEASED PLACE		74. DECEASED PLACE		75. DECEASED PLACE	
76. DECEASED PLACE		77. DECEASED PLACE		78. DECEASED PLACE	
79. DECEASED PLACE		80. DECEASED PLACE		81. DECEASED PLACE	
82. DECEASED PLACE		83. DECEASED PLACE		84. DECEASED PLACE	
85. DECEASED PLACE		86. DECEASED PLACE		87. DECEASED PLACE	
88. DECEASED PLACE		89. DECEASED PLACE		90. DECEASED PLACE	
91. DECEASED PLACE		92. DECEASED PLACE		93. DECEASED PLACE	
94. DECEASED PLACE		95. DECEASED PLACE		96. DECEASED PLACE	
97. DECEASED PLACE		98. DECEASED PLACE		99. DECEASED PLACE	
100. DECEASED PLACE		101. DECEASED PLACE		102. DECEASED PLACE	

RECEIVED
JAN 31 1957
BUREAU V. S.

750

CERTIFICATE OF DEATH

Reg. Dist. No. 202

1. PLACE OF DEATH o. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Kent</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>	c. LENGTH OF STAY IN 1b <u>life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>37 Chestertown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mt. Vernon Ave.</u>		d. STREET ADDRESS <u>Mt. Vernon Ave</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ella M. Reiche</u>		4. DATE OF DEATH Jan. 1, 1957 Month Day Year	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 12, 1865</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Kent Co. Maryland</u>
13. FATHER'S NAME <u>James Davis</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Copper</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>no</u>	17. INFORMANT <u>Mrs. S.S. Smith</u> Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>senility</u> <u>794X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>3 years at least</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>19 53</u> to <u>Jan. 2</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Jan. 2</u> , 19 <u>57</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chestertown, Md.</u> DATE SIGNED <u>I 2/57</u>			
ACTUAL SIGNATURE <u>Robert W. Farr</u> M.D.		PHYSICIAN'S NAME (Type) <u>Robert W. Farr - Chestertown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 4, 1957</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chester Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Chestertown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>		24a. REC'D BY REGISTRAR <u>Jan. 4-1957</u>	24b. REGISTRAR'S SIGNATURE <u>Clara S. Barnes</u>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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